BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOEL COHEN, M.D.** Holder of License No. **8027** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-04-0608A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 8, 2006. Joel Cohen, M.D., ("Respondent") appeared before the Board with legal counsel David S. Cohen for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 8027 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-04-0608A after receiving notification of a medical malpractice settlement involving Respondent's care and treatment of a thirty-three year-old female patient ("KC"). Respondent initially evaluated KC for chronic sinusitis on April 18, 2000. KC underwent a CT scan of her sinuses on April 20, 2000 and followed up with Respondent on April 28, 2000. At the follow-up visit Respondent diagnosed rhinosinusitis. On May 16, 2000 Respondent performed a septoplasty for a deviated septum that was restricting his endoscopic access to the sinuses and then he performed endoscopic sinus surgery.

4. On May 17, 2000 KC saw Respondent for packing removal. On May 22, 2000 Respondent's associate removed KC's septal splints and noted her complaint of a bump on the

bridge of her nose. On May 24, 2000 KC called Respondent's office complaining of a "sensitive bump" on her nose. KC saw Respondent on May 25, 2000. Respondent noted a "dorsal strut" and recommended observation for seven days. KC did not appear for a June 1, 2000 appointment. On June 2, 2000 Respondent wrote to KC's primary care physician that the cartilage graft might need to be removed. KC never returned to Respondent and on December 6, 2000 KC presented to another physician for a rhinoplasty to remove the cartilage graft from the bridge of her nose and place it in a more typical location in the columella.

5. Respondent testified in thirty-two years of practice in Arizona he has seen thousands of patients and has received advisory letters from the Board. Respondent testified he loves being a doctor, loves his practice, and has always tried to do the best he can. Respondent testified he tried to save KC from having to undergo a second operation by trying to correct the defect after the first surgery with a graft. Respondent noted the Board Medical Consultant's opinion that he placed the graft in the wrong position, but testified he has had a lot of experience and is a board fellow in the American Academy of Plastic and Reconstructive Surgery, a member of the College of Surgeons, and board certified for over thirty-five years. Respondent testified he put the graft in the right position and when KC came to see him the next day it was in the right position and there were no complaints. Respondent testified whatever happened to the graft to make it noticeable, which according to several people it was not, he did not know. Respondent testified he would have been more than happy to take the graft out at the operatory in his office, but he believes KC still would have needed another operation because she would not have been happy. Respondent testified he tried to save her from having the rhinoplasty by correcting the problem initially.

6. The Board directed Respondent to the Medical Consultant's report and noted it said the "proposed standard(s) of care and/or practice: The standard of care regarding revision septoplasty is a complex topic and certainly involves variation based on the judgment and

experience of the revising surgeon. The goal of any septoplasty is to correct irregularities in order to improve the flow of air within the nasal passages while avoiding compromise of the support of the nasal framework and its affect on the external appearance of the nose." Respondent testified this is exactly what he did; he gave KC support and was trying to avoid a compromise to the appearance of her nose.

7. The Board directed Respondent to the next paragraph in the Medical Consultant's report that notes Respondent deviated from the standard of care by placing a dorsal graft rather than a strut graft and that this is generally not accepted as adequate compensation for loss of nasal tip support, apparently the intended use in KC's case. The Board noted the Medical Consultant also opined it was not within the standard of care to attempt to remove such a graft in the office setting as proposed by Respondent once KC's problem was identified. Respondent testified he did not know if the Medical Consultant has the same amount of experience or the same expertise, and noted his own expert found he had done the right thing.

8. The Board asked Respondent if he had this case to do over again would he perform a strut graft instead of a dorsal graft. Respondent testified he would put the graft where he needed to make up for the major defect KC had in the dorsum of her nose. Respondent noted KC had a "saddle nose deformity" – a bump in the nose – and because of the collapse of the cartilage portion of the nose, there is a divot, a hole. Respondent noted this is where he would have put it because it gives support to the dorsum of the nose and it would correct any irregularity in the appearance of the outside of the nose. Respondent noted when KC had her final operation, in effect, she had the bump taken down so that it was even with the dorsum of the nose – a cosmetic procedure. Respondent testified he did not perform a cosmetic procedure, but a functional procedure. Respondent noted what he would have done differently is he would have mentioned it in his operative report.

9. Respondent directed the Board to KC's consent form that said "I have been advised that the purpose of the operation I have requested is improvement in function and/or appearance and not perfection; that the possibility of imperfection might ensue and the result might not live up to my expectations or goals which I have established. Further treatment may be necessary." Respondent testified there are many things that come up during surgery that a surgeon's experience and expertise has to take into account. Respondent testified he could not have done the graft, but then KC would have had the second operation for certain – and he was trying to save her from having a second operation. Respondent testified he cannot make every patient happy and did not try to hurt KC. Respondent testified if he had known he would be sued and have to come before the Board he would not have put the graft in and he would have let an unhappy KC go on her way and have someone else complete the rhinoplasty. Respondent testified he tried to do what was right at the time.

10. The Board asked Respondent whether his awareness and the problems that developed from placing the dorsal graft as opposed to the strut graft have caused him to rethink his approach in a case like KC's – would he in the future, if faced with a similar circumstance, perform a strut graft instead of a dorsal graft. Respondent testified that for KC he needed to perform a dorsal graft and noted that he performs strut grafts all the time. Respondent noted between the two grafts there is a three millimeter distance difference in location and he felt, and still feels, KC needed a dorsal graft because she had a complete rhinoplasty.

11. Respondent testified after the surgery he was asking KC to wait because he did not know if he would have to do anything. Respondent testified if KC had given it time and had not manipulated it to the point where there was nothing he could do to help it, it would have settled down, it would have looked fine – as it did at the time of the operation. Respondent noted there are other persons in the operating room and he asked the nurses if it looked right and everyone felt it looked terrific. The Board asked Respondent if on KC's follow-up visit he realized

there was a problem and offered to resolve the problem by removing the graft under local anesthetic in his office. Respondent testified he had. The Board noted Respondent must have realized something was there that he was not happy with. Respondent testified in his same office note he asked KC to wait a week and see if anything needed to be done, and if he had to do something, he told her one of the options was to take it out right in his office. The Board asked Respondent if he had done a surgery of that magnitude in his office and whether he thought a patient would be comfortable and able to tolerate the procedure under a local anesthetic in his office. Respondent answered the question in the affirmative.

12. The Board noted it had an opinion from a medical consultant that such a procedure would not be tolerated by KC and would be an unwise procedure to do in Respondent's office under a local anesthetic. The Board noted the operative report from the surgery KC ultimately underwent with another physician indicated a very extensive and complex procedure to bring things back to function and remove the defect. The Board asked Respondent if a procedure of such magnitude could be attempted in his office. Respondent testified he placed a two by three millimeter graft on the dorsum of her nose because he was trying to alleviate her having to go through major surgery. Respondent noted KC decided she wanted a rhinoplasty and this is completely different than what he did. Respondent testified he did a simple operation that he has done on numerous occasions under local anesthetic in his own operating room – a septoplasty through the interior of the nose – and there are no black and blue marks, no swelling, no reason for a splint, and no reason for the patient to be out of work. Respondent testified taking the graft out would have taken very little time and would have taken no more than a two millimeter incision under KC's nose. Respondent testified since he placed the graft he knew exactly where it was, how he put it in and how to take it out. The Board noted it had no documentation in the record that the graft was two by three millimeters and that Respondent's operative report does not allude at all to Respondent having done a graft.

13. The Board noted when KC was seen by other physicians seeking correction of the problem another CT scan was done approximately five weeks post-operatively. The Board directed Respondent to that CT scan. The Board compared this CT scan to the preoperative CT scan Respondent had and noted it seemed there were a lot more things going on with KC and the situation, instead of being improved, was worse. The Board asked why, five weeks later, things would appear to be so much worse, especially in regard to the left maxillary sinus. Respondent noted post-operative changes in x-rays are very common as in any surgical procedure. Respondent testified there was an acute fluid level because of the surgery. Respondent noted KC did not come back to him for post-operative care and post-operative care is very important and he would have seen her on multiple occasions.

14. The Board noted KC had two subsequent operations. The Board directed Respondent to the operative report of one of KC's subsequent treating physicians where he described the graft Respondent placed as being somewhat asymmetrical and there being a loss of significant support of the nose requiring he take the graft Respondent placed and move it to what he considered a proper position to reinforce it. The Board referred Respondent to this physician's letter dated November 9, approximately four months from the surgery Respondent performed that shows a lot of deficiencies even though the edema, the swelling, the healing would have taken place by this time. Respondent testified he did not create these deficiencies and a lot of the deficiencies were from KC's previous surgery. Respondent testified he was doing a revision surgery and trying to correct the nasal septal deviation, not to correct any of the external deformities that were apparent in the letter and this physician went to correct. Respondent testified he did not do a cosmetic operation and this physician was correcting cosmetic problems by doing an open rhinoplasty – a major operation. Respondent testified he performed a minor operation to correct only the obstruction in KC's nose. The Board asked if Respondent's surgery resulted in a cosmetic deformity that was unacceptable to KC and very

visible to physicians who saw her after his surgery. Respondent testified to him KC had no obvious cosmetic deformity. Respondent testified things changed between the time immediate post-op when he saw KC and she then saw at least three other physicians. The Board noted KC had seen other physicians and each described deformities and problems of a significant nature.

15. The Board directed Respondent to the consultation report of the plastic surgeon who saw KC on November 7, some five months after Respondent performed KC's surgery. The report notes "the only major problem that I see is this floating piece of cartilage over the dorsum of the nose. I told the patient that I usually wait one year prior to touching the nose after any nasal surgery because of the amount of scar tissue that develops. Once it settles down, if we correct things and the scar tissue continues to settle down, after we've corrected everything, we end up with a disaster on our hands." The Board asked if Respondent had any response to this report – whether this was something he would expect from the only one or two contacts he had with KC post-operatively. Respondent testified if he places the graft and it is left alone and not manipulated on a regular basis there is a chance it would have taken seat and would have been incorporated into the tissue and would have smoothed off as a callus would smooth off and the body kind of tends to want to take it on as its own. Respondent testified he thought the constant manipulation with the possibility of shift from constant touching and playing with it would have caused shift to occur and the graft not to heal. Respondent testified the only defect mentioned in the report was the shifting of cartilage.

16. The Board noted Respondent's operative dictation was fairly detailed yet, for some reason, Respondent failed to dictate anything about the graft he placed. The Board asked Respondent to explain why he failed to document this in his operative report. Respondent testified he had no excuse for that failure, but he had nothing to hide and did not omit it deliberately.

17. Respondent is required to maintain adequate medical records. Adequate medical records are legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. Respondent did not dictate the placement of the graft in his operative report.

18. The standard of care required Respondent to place a strut graft to compensate for loss of nasal support due to extensive cartilage loss.

19. Respondent deviated from the standard of care because he placed a dorsal graft that is generally not accepted as adequate compensation for loss of the nasal support tip.

20. KC was harmed because she required further revision surgeries to correct the deformity caused by the placement of the dorsal graft.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); and 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand for placing a dorsal graft instead of a strut graft requiring the patient to undergo additional revision surgery and for maintaining an inadequate medical record.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 6th day of April, 2006.

ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 7th day of April, 2006 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Certified Mail this
7th day of April, 2006, to:

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Executed copy of the foregoing
mailed by U.S. this 7th day
of April, 2006, to:

Joel G. Cohen, M.D.
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